pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **REFORMED PRESBYTERIAN WOMEN'S ASSOCIATION**
LEGAL ENTITY

To operate **REFORMED PRESBYTERIAN HOME**
NAME OF FACILITY OR AGENCY

Located at **2344 PERRYSVILLE AVENUE, PITTSBURGH, PA 15214**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

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ADDRESS OF SATELLITE SITE/SERVICE LOCATION

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **56**
(MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions:

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **July 8, 2025** until **July 8, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **429660**

ISSUING OFFICER

DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

HS 628 – 04/23

pennsylvania
DEPARTMENT OF HUMAN SERVICES

EMAILING DATE: JULY 8, 2025

[redacted]
Reformed Presbyterian Women's Association
[redacted]

RE: Reformed Presbyterian Home
2344 Perrysville Avenue
Pittsburgh, PA 15214
License #: 429660

Dear [redacted],

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing's (Department) licensing inspections on May 14, 2025 and May 30, 2025, and the corrections you have made after our inspection, we have found the above facility to be in compliance with Title 55, PA Code, Chapter 2600. Therefore, a regular license is being issued. Your license is enclosed.

Sincerely,

Juliet Marsala

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
License
Licensing Inspection Summary

Facility Information

Name: *REFORMED PRESBYTERIAN HOME* **License #**: *42966* **License Expiration**: *09/04/2025*

Address: *2344 PERRYSVILLE AVENUE, PITTSBURGH, PA 15214*

County: *ALLEGHENY* **Region**: *WESTERN*

Administrator

Name: [redacted]

Legal Entity

Name: *REFORMED PRESBYTERIAN WOMEN'S ASSOCIATION*

Address: *2344 PERRYSVILLE AVENUE, PITTSBURGH, PA, 15214*

Phone: [redacted]

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *10/10/1983* **Issued By**: *PA Dept L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *33* **Waking Staff**: *25*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal, Complaint, Provisional* **Exit Conference Date**: *05/30/2025*

Inspection Dates and Department Representative

05/14/2025 - On-Site: [redacted]

05/30/2025 - On-Site: [redacted]

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *56* **Residents Served**: *27*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *4*

Number of Residents Who:

Receive Supplemental Security Income: *2* **Are 60 Years of Age or Older**: *25*

Diagnosed with Mental Illness: *15* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *6* **Have Physical Disability**: *1*

Inspections / Reviews

05/14/2025 - Full

Lead Inspector: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/15/2025*

06/16/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *07/01/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *06/20/2025*

Inspections / Reviews *(continued)*

06/23/2025 - POC Submission

Submitted By: [redacted] **Date Submitted:** *07/01/2025*

Reviewer: [redacted] **Follow-Up Type:** *Document Submission* **Follow-Up Date:** *07/01/2025*

07/02/2025 - Document Submission

Submitted By: [redacted] **Date Submitted:** *07/01/2025*

Reviewer: [redacted] **Follow-Up Type:**

16c - Written Incident Report

1. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

On 5/14/25, licensing representative observed that resident #1's order for Amiodarone 200mg tablet changed from Amiodarone 200mg – take 1 tablet by mouth once daily to Amiodaron HCl 200mg tablet – Give 0.5 tablet by mouth one time a day for CHF hold for HR<55. This was brought to the attention of staff person A, Resident Care Director, on 5/14/25. According to medication technicians that administered the medication, the medication was not cut in half before being administered to the resident which resulted in a medication error. However, as of 5/30/25, the home had not submitted an incident report to the Department regarding this medication error.

Repeat Violation 11/7/24

Plan of Correction ***Accept [redacted] - 06/23/2025)***

PCHA sent reportable incident form to department on 6/10/2025. PCHA, Resident Care Director and staff re-educated on reportable incidents and conditions policy/ procedure by Executive Director and PCHA. Medication error and reportable incidents will be reported and reviewed at next QAPI meeting on July 15, 2025.

Medication error reporting to be audited with RPH Orders audit weekly for 2 months, then bi weekly for 1 month, then monthly. Audit will be conducted by PCHA, Resident Care Director or Designee. Reportable Incidents and Audits will be kept in a folder/ binder in the Resident Care Director's Office.

Licensee's Proposed Overall Completion Date: *06/20/2025*

Implemented [redacted] - 07/02/2025)

63a - First Aid/CPR Training

2. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On Saturday, 5/3/25, the home served 23 residents. However, there was no staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 11:00 p.m. through 6:30 a.m. on 5/4/25.

On Sun, 5/11/25, the home served 25 residents. However, there was no staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 11:00 p.m. through 6:30 a.m. on 5/12/25.

On Weds, 5/14/25, the home served 25 residents. However, there was no staff trained in first aid and certified in obstructed airway techniques and CPR present in the home from 11:00 p.m. through 6:30 a.m. on 5/15/25.

Plan of Correction ***Accept [redacted] - 06/23/2025)***

PC Scheduler, or designee will completes a biweekly schedule that includes at least one staff person for every 50 residents who is trained in first aid/certified in obstructed airway techniques/CPR will be in the home at all times. Scheduling will begin on 6/18/2025. As of 6/18/25, all PCH staff are CPR/ first aid certified.

63a - First Aid/CPR Training (continued)

PCHA or designee will complete a weekly review of the actual staff persons who worked in the home to ensure at least one staff person for every 50 residents is trained in first aid/certified in obstructed airway techniques/CPR was in the home at all times. This review will begin 6/25/25. Weekly schedule will be printed out and initialed to indicate all shifts have at least one staff person who is CPR/ First Aid certified.

CPR and First Aid class scheduled for 6/18/25, both night shift caregivers who were not CPR/ First Aid certified are scheduled to participate as well as all other PC staff whose certification is lapsed.

Audit of all PC staff for certification and scheduling of classes will be conducted at least quarterly by PCHA, Human Resources, or designee starting 6/17/2025.

Licensee's Proposed Overall Completion Date: *06/25/2025*

Implemented [redacted] - 07/02/2025)

65b - Rights/Abuse 40 Hours

3. Requirements

2600.
65.b. Within 40 scheduled working hours, direct care staff persons, ancillary staff persons, substitute personnel and volunteers shall have an orientation that includes the following:
2. Emergency medical plan.
4. Reporting of reportable incidents and conditions.

Description of Violation

Direct care staff person B started working for the home on [redacted]/24. However, staff person B did not receive training in Emergency Medical Plan and Reporting of Reportable Incidents and Conditions until 11/11/2024.

Repeat Violation 8/22/24

Plan of Correction ***Accept [redacted] - 06/23/2025)***

All PC staff will be re-educated on Emergency Medical Plan and reporting of Reportable incidents/ conditions. Orientation for new employees will include the same training with a sign-off to indicate training was received and understood within the first 40 hours of starting with the PCH.

An audit of new staff records will be completed by PCHA, Human Resources, or designee at least quarterly to ensure compliance with staff orientation in accordance with 2600.65b

Documentation of Staff person B's training in Emergency Medical Plan on 7/18/24 prior to starting 7/26/24 and re-training on 11/11/24 is attached.

Licensee's Proposed Overall Completion Date: *06/25/2025*

Implemented [redacted] - 07/02/2025)

90b - Staff Communication

4. Requirements

2600.

90b - Staff Communication *(continued)*

90.b. For a home serving 9 or more residents, there shall be a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Description of Violation

On 5/30/25, the home served 26 residents. However, the home does not have a system or method of communication that enables staff persons to immediately contact other staff persons in the home for assistance in an emergency.

Plan of Correction ***Directed [redacted] - 06/23/2025)***

PCHA ordered and gave staff walkie-talkies on 6/19/25 as a means of immediate communication between staff for assistance in an emergency in accordance with 2600.90b.
All staff will be educated to new equipment and process of communicating appropriately over walkies with one another.

Proposed Overall Completion Date: 06/20/2025

Directed
Within two days of receipt of the plan of correction: The administrator or designated staff person shall check the operability of the two-way radios daily to ensure all radios are in working order. Documentation of checks shall be kept. [redacted] 6/23/25

Directed Completion Date: *06/25/2025*

Implemented [redacted] - 07/02/2025)

132c - Fire Drill Records

5. Requirements

2600.
132.c. A written fire drill record must include the date, time, the amount of time it took for evacuation, the exit route used, the number of residents in the home at the time of the drill, the number of residents evacuated, the number of staff persons participating, problems encountered and whether the fire alarm or smoke detector was operative.

Description of Violation

According to interviews, all residents are evacuated to a fire safe area for each fire drill. However, the documentation for the fire drill conducted on 4/21/25 at 1:30 p.m. indicates that only 9 of 76 total residents in the building were evacuated, and the documentation for the fire drill conducted on 5/29/25 at 3:11 p.m. indicates that only 5 of 27 residents on personal care floor were evacuated.

Repeat Violation 8/22/24

Plan of Correction ***Accept [redacted] - 06/23/2025)***

Fire Drill Record Form was corrected with the actual number of residents evacuated for the dates or 4/21/25 and 5/29/25 by Director of Facilities on 5/14/25 when it was brought to [redacted] attention.
Director of Facilities, PCHA and RCD will be re-educated 6/20/2025 by Executive Director on proper completion of Fire Drill records utilizing the PCH Fire Drill Record Form and ensuring the correct number of residents that have been evacuated is recorded.
PCHA or RCD will be responsible for auditing that form has been completed accurately monthly, at the end of the month starting 6/30/25. Audit will be indicated by initialing/ dating the Fire Drill Record form next to the last column on the form.

Licensee's Proposed Overall Completion Date: *06/30/2025*

132c - Fire Drill Records *(continued)*

Implemented [redacted] - 07/02/2025)

184a - Resident's Meds Labeled

6. Requirements

2600.
184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:
4. The prescribed dosage and instructions for administration.

Description of Violation

Resident #1 is ordered Amiodaron HCl 200mg tablet – Give 0.5 tablet by mouth one time a day for CHF hold for HR<55. However, on 5/14/25 at 3:45 p.m., the pharmacy label on the blister pack of this medication indicated Amiodarone 200mg – take 1 tablet by mouth once daily.

Repeat Violation 6/14/24

Plan of Correction ***Directed ([redacted] 06/23/2025)***

Resident's Amiodarone order was updated and a new blister pack of split tablets was ordered from Rx Partners by Resident Care Director 5/14/25.

Med Tech staff will be re-educated starting 6/19/25 by Resident Care Director on process when an order changes and making sure the order matches the label on the medication packaging.

Medication order changes will be randomly audited weekly starting 6/20/25 for 3 months, bi-weekly for 3 months and monthly thereafter as long as compliance is maintained at 100%. If compliance is not 100%, weekly audits will resume. Audits will be completed by Resident Care Director or designee and kept in folder/binder in RCD office.

Proposed Overall Completion Date: 06/20/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator or designated staff person qualified to administer medications shall audit all medication changes for three months then bi-weekly for 3 months and monthly thereafter as long as compliance is maintained at 100%. If compliance is not 100%, weekly audits will resume. Audits will be completed by Resident Care Director or designee and kept in folder/binder in RCD office. [redacted] 6/23/25

Directed Completion Date: *06/24/2025*

Implemented [redacted] - 07/02/2025)

187d - Follow Prescriber's Orders

7. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is ordered Amiodaron HCl 200mg tablet – Give 0.5 tablet by mouth one time a day for CHF hold for HR<55. The order was changed on 5/8/25 from Amiodarone 200mg – take 1 tablet by mouth once daily. On 5/14/25

187d - Follow Prescriber's Orders (continued)

at 3:45 p.m., the pharmacy label on the blister pack of this medication indicated Amiodarone 200mg – take 1 tablet by mouth once daily. According to interviews with staff persons C and D, medication technicians, Amiodarone 200mg tablets were administered as a whole tablet on 5/9/25, 5/10/25, 5/11/25, 5/13/25 and 5/14/25.

Repeat Violation 6/14/24

Plan of Correction ***Directed [redacted]/23/2025)***

Med Tech staff will be re-educated starting 6/19/25 by Resident Care Director on following prescribers orders, medication changes and ensuring label matches the order.

Medication order changes will be randomly audited weekly starting 6/20/25 for 3 months, bi-weekly for 3 months and monthly thereafter as long as compliance is maintained at 100%. If compliance is not 100%, weekly audits will resume. Audits will be completed by Resident Care Director or designee and kept in folder/binder in RCD office. Medication order changes will be randomly audited weekly for 2 months, bi-weekly for 1 month and monthly thereafter.

PCHA sent reportable incident form to department on 6/10/2025 for resident's Amiodarone medication error. Resident and physician notified of error on 5/14/25 by Resident Care Director per Medication Incident Report. Medication error is noted in resident's progress notes by PCHA on 6/10/25.

Medication error and reportable incidents will be reported and reviewed at next QAPI meeting on July 15, 2025.

Proposed Overall Completion Date: 06/27/2025

DIRECTED
Within one day of receipt of the plan of correction: The administrator or designated staff person qualified to administer medications shall audit all medication changes for three months then, bi-weekly for 3 months and monthly thereafter as long as compliance is maintained at 100%. If compliance is not 100%, weekly audits will resume. Audits will be completed by Resident Care Director or designee and kept in folder/binder in RCD office. Medication order changes will be randomly audited weekly for 2 months, bi-weekly for 1 month and monthly thereafter. [redacted] 6/23/25

Directed Completion Date: *06/27/2025*

Implemented [redacted]/02/2025)